UNITED STATES DISTRICT COURT
DISTRICT OF RHODE ISLAND

ANDREE A.	:	
	:	
v.	:	C.A. No. 18-00470-WES
	:	
ANDREW SAUL, Commissioner of the Social Security Administration	:	

REPORT AND RECOMMENDATION

Lincoln D. Almond, United States Magistrate Judge

This matter is before the Court for judicial review of a final decision of the Commissioner of the Social Security Administration ("Commissioner") denying Disability Insurance Benefits ("DIB") under the Social Security Act (the "Act"), 42 U.S.C. § 405(g). Plaintiff filed her Complaint on August 24, 2018 seeking to reverse the Decision of the Commissioner. On March 27, 2019, Plaintiff filed a Motion for Reversal of the Disability Determination of the Decision of the Commissioner of Social Security. (ECF No. 14). On June 4, 2019, the Commissioner filed a Motion for an Order Affirming the Decision of the Commissioner. (ECF No. 17). On July 1, 2019, Plaintiff filed a Reply Brief. (ECF No. 20).

This matter has been referred to me for preliminary review, findings and recommended disposition. 28 U.S.C. § 636(b)(1)(B); LR Cv 72. Based upon my review of the record, the parties' submissions and independent research, I find that there is not substantial evidence in this record to support the Commissioner's decision and findings that Plaintiff is not disabled within the meaning of the Act. Consequently, I recommend that

Plaintiff's Motion for Reversal (ECF No. 14) be GRANTED and that the Commissioner's Motion to Affirm (ECF No. 17) be DENIED.

I. PROCEDURAL HISTORY

Plaintiff filed an application for DIB on August 5, 2016 (Tr. 141-142) alleging disability since April 30, 2015. The application was denied initially on December 29, 2016 (Tr. 63-71) and on reconsideration on February 15, 2017. (Tr. 73-80). Plaintiff requested an Administrative Hearing. On October 26, 2017, a hearing was held before Administrative Law Judge Barry H . Best (the "ALJ") at which time Plaintiff, represented by counsel, and a Vocational Expert ("VE") appeared and testified. (Tr. 35-62). The ALJ issued an unfavorable decision to Plaintiff on December 1, 2017. (Tr. 23-34). The Appeals Council denied Plaintiff's request for review on June 25, 2018. (Tr. 1-6). Therefore, the ALJ's decision became final. A timely appeal was then filed with this Court.

II. THE PARTIES' POSITIONS

Plaintiff argues that the ALJ's Step 2 denial is not sustainable.

The Commissioner disputes Plaintiff's claims and contends that the Step 2 denial is supported by substantial evidence and must be affirmed.

III. THE STANDARD OF REVIEW

The Commissioner's findings of fact are conclusive if supported by substantial evidence. 42 U.S.C. § 405(g). Substantial evidence is more than a scintilla – i.e., the evidence must do more than merely create a suspicion of the existence of a fact, and must include such relevant evidence as a reasonable person would accept as adequate to support

the conclusion. Ortiz v. Sec'y of HHS, 955 F.2d 765, 769 (1st Cir. 1991) (per curiam); Rodriguez v. Sec'y of HHS, 647 F.2d 218, 222 (1st Cir. 1981).

Where the Commissioner's decision is supported by substantial evidence, the court must affirm, even if the court would have reached a contrary result as finder of fact. Rodriguez Pagan v. Sec'y of HHS, 819 F.2d 1, 3 (1st Cir. 1987); Barnes v. Sullivan, 932 F.2d 1356, 1358 (11th Cir. 1991). The court must view the evidence as a whole, taking into account evidence favorable as well as unfavorable to the decision. Frustaglia v. Sec'y of HHS, 829 F.2d 192, 195 (1st Cir. 1987); Parker v. Bowen, 793 F.2d 1177 (11th Cir. 1986) (court also must consider evidence detracting from evidence on which Commissioner relied).

The court must reverse the ALJ's decision on plenary review, however, if the ALJ applies incorrect law, or if the ALJ fails to provide the court with sufficient reasoning to determine that he or she properly applied the law. Nguyen v. Chater, 172 F.3d 31, 35 (1st Cir. 1999) (per curiam); accord Cornelius v. Sullivan, 936 F.2d 1143, 1145 (11th Cir. 1991). Remand is unnecessary where all of the essential evidence was before the Appeals Council when it denied review, and the evidence establishes without any doubt that the claimant was disabled. Seavey v. Barnhart, 276 F.3d 1, 11 (1st Cir. 2001) citing, Mowery v. Heckler, 771 F.2d 966, 973 (6th Cir. 1985).

The court may remand a case to the Commissioner for a rehearing under sentence four of 42 U.S.C. § 405(g); under sentence six of 42 U.S.C. § 405(g); or under both sentences. Seavey, 276 F.3d at 8. To remand under sentence four, the court must either find that the Commissioner's decision is not supported by substantial evidence, or that the Commissioner incorrectly applied the law relevant to the disability claim. Id.; accord

Brenem v. Harris, 621 F.2d 688, 690 (5th Cir. 1980) (remand appropriate where record was insufficient to affirm, but also was insufficient for district court to find claimant disabled).

Where the court cannot discern the basis for the Commissioner's decision, a sentence-four remand may be appropriate to allow her to explain the basis for her decision. Freeman v. Barnhart, 274 F.3d 606, 609-610 (1st Cir. 2001). On remand under sentence four, the ALJ should review the case on a complete record, including any new material evidence. Diorio v. Heckler, 721 F.2d 726, 729 (11th Cir. 1983) (necessary for ALJ on remand to consider psychiatric report tendered to Appeals Council). After a sentence four remand, the court enters a final and appealable judgment immediately, and thus loses jurisdiction. Freeman, 274 F.3d at 610.

In contrast, sentence six of 42 U.S.C. § 405(g) provides:

> The court...may at any time order additional evidence to be taken before the Commissioner of Social Security, but only upon a showing that there is new evidence which is material and that there is good cause for the failure to incorporate such evidence into the record in a prior proceeding;

42 U.S.C. § 405(g). To remand under sentence six, the claimant must establish: (1) that there is new, non-cumulative evidence; (2) that the evidence is material, relevant and probative so that there is a reasonable possibility that it would change the administrative result; and (3) there is good cause for failure to submit the evidence at the administrative level. See Jackson v. Chater, 99 F.3d 1086, 1090-1092 (11th Cir. 1996).

A sentence six remand may be warranted, even in the absence of an error by the Commissioner, if new, material evidence becomes available to the claimant. Id. With a sentence six remand, the parties must return to the court after remand to file modified

findings of fact. Id. The court retains jurisdiction pending remand, and does not enter a final judgment until after the completion of remand proceedings. Id.

IV. THE LAW

The law defines disability as the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than twelve months. 42 U.S.C. §§ 416(i), 423(d)(1); 20 C.F.R. § 404.1505. The impairment must be severe, making the claimant unable to do her previous work, or any other substantial gainful activity which exists in the national economy. 42 U.S.C. § 423(d)(2); 20 C.F.R. §§ 404.1505-404.1511.

A. Treating Physicians

Substantial weight should be given to the opinion, diagnosis and medical evidence of a treating physician unless there is good cause to do otherwise. See Rohrberg v. Apfel, 26 F. Supp. 2d 303, 311 (D. Mass. 1998); 20 C.F.R. § 404.1527(d). If a treating physician's opinion on the nature and severity of a claimant's impairments is well-supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the record, the ALJ must give it controlling weight. 20 C.F.R. § 404.1527(d)(2). The ALJ may discount a treating physician's opinion or report regarding an inability to work if it is unsupported by objective medical evidence or is wholly conclusory. See Keating v. Sec'y of HHS, 848 F.2d 271, 275-276 (1st Cir. 1988).

Where a treating physician has merely made conclusory statements, the ALJ may afford them such weight as is supported by clinical or laboratory findings and other

consistent evidence of a claimant's impairments. See Wheeler v. Heckler, 784 F.2d 1073, 1075 (11th Cir. 1986). When a treating physician's opinion does not warrant controlling weight, the ALJ must nevertheless weigh the medical opinion based on the (1) length of the treatment relationship and the frequency of examination; (2) the nature and extent of the treatment relationship; (3) the medical evidence supporting the opinion; (4) consistency with the record as a whole; (5) specialization in the medical conditions at issue; and (6) other factors which tend to support or contradict the opinion. 20 C.F.R § 404.1527(c). However, a treating physician's opinion is generally entitled to more weight than a consulting physician's opinion. See 20 C.F.R. § 404.1527(c)(2).

The ALJ is required to review all of the medical findings and other evidence that support a medical source's statement that a claimant is disabled. However, the ALJ is responsible for making the ultimate determination about whether a claimant meets the statutory definition of disability. 20 C.F.R. § 404.1527(e). The ALJ is not required to give any special significance to the status of a physician as treating or non-treating in weighing an opinion on whether the claimant meets a listed impairment, a claimant's residual functional capacity (see 20 C.F.R. §§ 404.1545 and 404.1546), or the application of vocational factors because that ultimate determination is the province of the Commissioner. 20 C.F.R. § 404.1527(e). See also Dudley v. Sec'y of HHS, 816 F.2d 792, 794 (1st Cir. 1987).

B. Developing the Record

The ALJ has a duty to fully and fairly develop the record. Heggarty v. Sullivan, 947 F.2d 990, 997 (1st Cir. 1991). The Commissioner also has a duty to notify a claimant of the

statutory right to retained counsel at the social security hearing, and to solicit a knowing and voluntary waiver of that right if counsel is not retained. See 42 U.S.C. § 406; Evangelista v. Sec'y of HHS, 826 F.2d 136, 142 (1st Cir. 1987). The obligation to fully and fairly develop the record exists if a claimant has waived the right to retained counsel, and even if the claimant is represented by counsel. Id. However, where an unrepresented claimant has not waived the right to retained counsel, the ALJ's obligation to develop a full and fair record rises to a special duty. See Heggarty, 947 F.2d at 997, citing Currier v. Sec'y of Health Educ. and Welfare, 612 F.2d 594, 598 (1st Cir. 1980).

C. Medical Tests and Examinations

The ALJ is required to order additional medical tests and exams only when a claimant's medical sources do not give sufficient medical evidence about an impairment to determine whether the claimant is disabled. 20 C.F.R. § 416.917; see also Conley v. Bowen, 781 F.2d 143, 146 (8th Cir. 1986). In fulfilling his duty to conduct a full and fair inquiry, the ALJ is not required to order a consultative examination unless the record establishes that such an examination is necessary to enable the ALJ to render an informed decision. Carrillo Marin v. Sec'y of HHS, 758 F.2d 14, 17 (1st Cir. 1985).

D. The Five-step Evaluation

The ALJ must follow five steps in evaluating a claim of disability. See 20 C.F.R. §§ 404.1520, 416.920. First, if a claimant is working at a substantial gainful activity, she is not disabled. 20 C.F.R. § 404.1520(b). Second, if a claimant does not have any impairment or combination of impairments which significantly limit her physical or mental ability to do basic work activities, then she does not have a severe impairment and is not disabled. 20

C.F.R. § 404.1520(c). Third, if a claimant's impairments meet or equal an impairment listed in 20 C.F.R. Part 404, Subpart P, Appendix 1, she is disabled. 20 C.F.R. § 404.1520(d). Fourth, if a claimant's impairments do not prevent her from doing past relevant work, she is not disabled. 20 C.F.R. § 404.1520(e). Fifth, if a claimant's impairments (considering her residual functional capacity, age, education, and past work) prevent her from doing other work that exists in the national economy, then she is disabled. 20 C.F.R. § 404.1520(f). Significantly, the claimant bears the burden of proof at steps one through four, but the Commissioner bears the burden at step five. Wells v. Barnhart, 267 F. Supp. 2d 138, 144 (D. Mass. 2003) (five-step process applies to both SSDI and SSI claims).

In determining whether a claimant's physical and mental impairments are sufficiently severe, the ALJ must consider the combined effect of all of the claimant's impairments, and must consider any medically severe combination of impairments throughout the disability determination process. 42 U.S.C. § 423(d)(2)(B). Accordingly, the ALJ must make specific and well-articulated findings as to the effect of a combination of impairments when determining whether an individual is disabled. Davis v. Shalala, 985 F.2d 528, 534 (11th Cir. 1993).

The claimant bears the ultimate burden of proving the existence of a disability as defined by the Social Security Act. Seavey, 276 F.3d at 5. The claimant must prove disability on or before the last day of her insured status for the purposes of disability benefits. Deblois v. Sec'y of HHS, 686 F.2d 76 (1st Cir. 1982), 42 U.S.C. §§ 416(i)(3), 423(a), (c). If a claimant becomes disabled after she has lost insured status, her claim for disability benefits must be denied despite her disability. Id.

E. Other Work

Once the ALJ finds that a claimant cannot return to her prior work, the burden of proof shifts to the Commissioner to establish that the claimant could perform other work that exists in the national economy. Seavey, 276 F.3d at 5. In determining whether the Commissioner has met this burden, the ALJ must develop a full record regarding the vocational opportunities available to a claimant. Allen v. Sullivan, 880 F.2d 1200, 1201 (11th Cir. 1989). This burden may sometimes be met through exclusive reliance on the Medical-Vocational Guidelines (the "grids"). Seavey, 276 F.3d at 5. Exclusive reliance on the "grids" is appropriate where the claimant suffers primarily from an exertional impairment, without significant non-exertional factors. Id.; see also Heckler v. Campbell, 461 U.S. 458 (1983) (exclusive reliance on the grids is appropriate in cases involving only exertional impairments, impairments which place limits on an individual's ability to meet job strength requirements).

Exclusive reliance is not appropriate when a claimant is unable to perform a full range of work at a given residual functional level or when a claimant has a non-exertional impairment that significantly limits basic work skills. Nguyen, 172 F.3d at 36. In almost all of such cases, the Commissioner's burden can be met only through the use of a vocational expert. Heggarty, 947 F.2d at 996. It is only when the claimant can clearly do unlimited types of work at a given residual functional level that it is unnecessary to call a vocational expert to establish whether the claimant can perform work which exists in the national economy. See Ferguson v. Schweiker, 641 F.2d 243, 248 (5th Cir. 1981). In any event, the ALJ must make a specific finding as to whether the non-exertional limitations are severe

enough to preclude a wide range of employment at the given work capacity level indicated by the exertional limitations.

1. Pain

"Pain can constitute a significant non-exertional impairment." Nguyen, 172 F.3d at 36. Congress has determined that a claimant will not be considered disabled unless he furnishes medical and other evidence (e.g., medical signs and laboratory findings) showing the existence of a medical impairment which could reasonably be expected to produce the pain or symptoms alleged. 42 U.S.C. § 423(d)(5)(A). The ALJ must consider all of a claimant's statements about his symptoms, including pain, and determine the extent to which the symptoms can reasonably be accepted as consistent with the objective medical evidence. 20 C.F.R. § 404.1528. In determining whether the medical signs and laboratory findings show medical impairments which reasonably could be expected to produce the pain alleged, the ALJ must apply the First Circuit's six-part pain analysis and consider the following factors:

> (1) The nature, location, onset, duration, frequency, radiation, and intensity of any pain;
>
> (2) Precipitating and aggravating factors (e.g., movement, activity, environmental conditions);
>
> (3) Type, dosage, effectiveness, and adverse side-effects of any pain medication;
>
> (4) Treatment, other than medication, for relief of pain;
>
> (5) Functional restrictions; and
>
> (6) The claimant's daily activities.

Avery v. Sec'y of HHS, 797 F.2d 19, 29 (1st Cir. 1986). An individual's statement as to pain is not, by itself, conclusive of disability. 42 U.S.C. § 423(d)(5)(A).

2. Credibility

Where an ALJ decides not to credit a claimant's testimony about pain, the ALJ must articulate specific and adequate reasons for doing so, or the record must be obvious as to the credibility finding. Rohrberg, 26 F. Supp. 2d at 309. A reviewing court will not disturb a clearly articulated credibility finding with substantial supporting evidence in the record. See Frustaglia, 829 F.2d at 195. The failure to articulate the reasons for discrediting subjective pain testimony requires that the testimony be accepted as true. See DaRosa v. Sec'y of Health and Human Servs., 803 F.2d 24 (1st Cir. 1986).

A lack of a sufficiently explicit credibility finding becomes a ground for remand when credibility is critical to the outcome of the case. See Smallwood v. Schweiker, 681 F.2d 1349, 1352 (11th Cir. 1982). If proof of disability is based on subjective evidence and a credibility determination is, therefore, critical to the decision, "the ALJ must either explicitly discredit such testimony or the implication must be so clear as to amount to a specific credibility finding." Foote v. Chater, 67 F.3d 1553, 1562 (11th Cir. 1995) (quoting Tieniber v. Heckler, 720 F.2d 1251, 1255 (11th Cir. 1983)).

V. APPLICATION AND ANALYSIS

A. The ALJ's Decision

The ALJ decided this DIB case adverse to Plaintiff at Step 2. The ALJ determined that Plaintiff's MRSA infections and back disorder were not "severe" impairments because they did not significantly limit the ability to perform basic work activities "for 12

consecutive months." (Tr. 26). Thus, the ALJ concluded that Plaintiff was not disabled at any time from April 30, 2015, the date of onset, through December 31, 2015, the date last insured for DIB. (Tr. 30).

B. The ALJ's Step 2 Denial is Not Supported by the Record

It is undisputed that the relevant period in this DIB case is narrow. Plaintiff alleges disability onset as of April 30, 2015 and her date last insured for DIB is December 31, 2015. Thus, Plaintiff must establish that "her impairment(s) reached a disabling level of severity by that date." Rivera v. Sec'y of HHS, 19 F.3d 1427 at *5 (1st Cir. 1994) (unpublished opinion) (citing Deblois v. Sec'y of HHS, 686 F.2d 76, 79 (1st Cir. 1982). "It is not sufficient…to establish that [an] impairment had its roots before the date that her insured status expired." Id. However, "[m]edical evidence generated after…insured status expires may be considered for what light (if any) it sheds on the question whether claimant's impairment(s) reached disability severity before…insured status expired." Id.

Here, Plaintiff argues that the ALJ erred by taking an "unfairly myopic view" of the relevant period which "foreclose[d] the possibility that [Plaintiff] had an impairment that 'can be expected to last' for the requisite 12 month time period." (ECF No. 14-1 at p. 18); see also 20 C.F.R. §§ 404.1505(a) and 404.1509. Pursuant to 20 C.F.R. §§ 404.1509 and 416.909, a non-fatal impairment "must have lasted or must be expected to last for a continuous period of at least 12 months" to qualify as disabling. This duration requirement applies to both the impairment and the inability-to-work requirements of the Social Security Act. See Barnhart v. Walton, 535 U.S. 212, 222-223 (2002). Plaintiff here faults the ALJ

(and the state agency consulting physicians) for taking an overly narrow view of her medical history. I agree.

The ALJ determined that Plaintiff had the medically determinable impairments of MRSA infections and a back disorder through the date last insured but found at Step 2 that she did not have any "severe" impairments during the relevant period. (Tr. 26-30). The ALJ relied primarily on the opinions of the state agency physicians, Dr. Quinn (Exh. 1A) and Dr. Laurelli (Exh. 3A). (Tr. 29).[1]

An impairment is not "severe" when it does not significantly limit a claimant's physical or mental ability to do basic work activities. 20 C.F.R. § 404.1520(c). The Commissioner has adopted a "slight abnormality" standard which provides that an impairment is "non-severe" when the medical evidence establishes only a slight abnormality that has "no more than a minimal effect on an individual's ability to work." Social Security Ruling ("SSR") 85-28. "The step two inquiry is a de minimis screening device used to dispose of groundless or frivolous claims." Orellana v. Astrue, 547 F. Supp. 2d 1169, 1172 (E.D. Wash. 2008) (citing Bowen v. Yuckert, 482 U.S. 137, 153-154 (1987)); see also Lisi v. Apfel, 111 F. Supp. 2d 103, 110 (D.R.I. 2000).

The "slight abnormality" standard requires that "[a] claim may be denied at step two only if the evidence shows that the individual's impairments, when considered in combination, are not medically severe, i.e., do not have more than a minimal effect on the person's physical or mental ability(ies) to perform basic work activities." SSR 85-28 at p. 3. "If such a finding is

[1] Alternatively, Plaintiff persuasively argues that the state agency physicians failed to review the opinions of Nurse Vilmenay (Exh. 5F). (Tr. 70, 79 – noting the lack of any "medical or other opinion evidence"). Also, neither consulting physician explanation suggests that they were aware of the November 2015 assault, back injury and subsequent back surgery. (Exhs. 1A and 3A).

not clearly established by medical evidence, however, adjudication must continue through the sequential evaluation process." Id.

Frankly, this is a fairly close case with limited evidence during the relevant period. However, on balance, there are a couple of findings in the ALJ's analysis that are irreconcilable with the record, and warrant remand and further evaluation. First, the ALJ found that, during the relevant period, Plaintiff was "seen for conditions that resolved with limited treatment and were not recurrent or chronic." (Tr. 28). One of those conditions was MRSA. While Plaintiff was treated for a single MRSA infection in September 2015 that resulted in a brief hospitalization, there is no support in the record for the ALJ finding that the condition was "not recurrent or chronic." Id. Plaintiff has a well-documented history of recurrent MRSA infections dating back to 2011. (See, e.g., Tr. 316, 394 noting "recurrent MRSA skin abscesses of her hands, feet, legs, & back since 2011."). Her hospital record dated September 1, 2015 notes that her past medical history is "consistent for recurring MRSA abscesses/skin infections that have been operatively managed." (Tr. 254). Following her 2015 hospitalization, Plaintiff was seen in the infectious disease clinic and underwent "decolonization therapy." (Tr. 260, 533).

The medical records after Plaintiff's date last insured also reflect ongoing MRSA issues. For instance, on April 29, 2016, Plaintiff requested a refill of Bactrim to address "recurrent aggressive abscess formation." (Tr. 449). She reported an issue with her left hand continuing to drain and not healing. (Tr. 449-450). She indicated that "she continually gets these and sometimes will end up in the hospital for IV antibiotics." Id. On May 31, 2016, the record noted Plaintiff's MRSA history with "current left buttock infection

(cellulitis)." (Tr. 506). On January 23, 2017, Plaintiff was admitted into Miriam Hospital with "a large and severe-looking R foot infection." (Tr. 515). She was assessed with "sepsis secondary to her MRSA infection." (Tr. 522). The second toe on Plaintiff's right foot was amputated as a result. (Tr. 568). She was discharged from Miriam on January 30, 2017 and spent three days in an extended care rehab hospital. (Tr. 676). Given this history, there is simply no evidentiary basis in the record for the ALJ's finding that Plaintiff's 2015 MRSA infection was a condition that was "not recurrent or chronic." (Tr. 28).

Second, the ALJ makes conflicting findings regarding Plaintiff's back impairment. While he concludes that she has a medically determinable back disorder through the date last insured (Tr. 26), the ALJ also makes a point of noting that there was "no mention of any back problem or need for surgery during the period at issue." (Tr. 28). If the ALJ found that Plaintiff had a back disorder, then it follows that he necessarily found her testimony about the 2015 injury to be credible since it is the primary evidence in the record. Moreover, there is substantial, credible evidence in the record that Plaintiff was the victim of domestic violence on November 3, 2015. (Tr. 46-47, 182, 193, 234 and 294); see also State v. Melzmuf, Case No. P2-2016-0471ADV (Prov. Cty. Sup. Ct.). Plaintiff testified credibly as to the violent assault and back injury. (Tr. 46-47). She thought the injury was just sciatic with spasms and she did not initially seek treatment until "around Christmas time" when she "couldn't even stand." (Tr. 47). Ultimately, after consulting with Dr. Daniels and having an MRI, Plaintiff had back surgery on July 12, 2016. (Tr. 289). The history taken in the Rhode Island Hospital surgical procedure record dated July 13, 2016 indicates that Plaintiff had nine months of left leg pain which is consistent with her report of being injured during

the November 3, 2015 domestic assault. (Tr. 294). Finally, it does not appear that the July surgery resolved Plaintiff's back problems. (See, e.g., Tr. 497).

If you look at this "closed" eight-month period of disability in a vacuum, you see a single MRSA infection that resolved with treatment and a claimed back injury with no medical treatment sought. Such a record by itself would likely support a Step 2 denial. However, that is not this case. Plaintiff has a credible record of chronic MRSA infections over several years requiring wound self-care and, often, hospitalization and surgical procedures. There is also a credible record of a back injury due to a violent domestic assault committed on Plaintiff prior to her date last insured, back surgery within nine months of this assault and medical records of subsequent back issues. Remand is warranted to further review these conditions in historical context to determine if they meet the Step 2 severity standard prior to the date last insured.

CONCLUSION

For the reasons discussed herein, I recommend that Plaintiff's Motion for Reversal (ECF No. 14) be GRANTED and that the Commissioner's Motion to Affirm (ECF No. 17) be DENIED. I further recommend that Final Judgment enter in favor of Plaintiff remanding this matter for further administrative proceedings consistent with this decision.

Any objection to this Report and Recommendation must be specific and must be filed with the Clerk of the Court within fourteen days of its receipt. See Fed. R. Civ. P. 72(b); LR Cv 72. Failure to file specific objections in a timely manner constitutes waiver of the right to review by the District Court and the right to appeal the District Court's decision. See

United States v. Valencia-Copete, 792 F.2d 4, 6 (1st Cir. 1986); Park Motor Mart, Inc. v. Ford Motor Co., 616 F.2d 603, 605 (1st Cir. 1980).

/s/ Lincoln D. Almond
LINCOLN D. ALMOND
United States Magistrate Judge
October 10, 2019